# NORTH CAROLINA SCHIP REVIEW REPORT

## Executive Summary

The monitoring review of North Carolina's SCHIP program, know as North Carolina Health Choice for Children (Health Choice), was conducted by the Region IV SCHIP team during the week of April 24 – 28, 2000. The following are the major findings and recommendations of the review team.

North Carolina's original baseline estimate of eligible children was 71,000. The State contends the Current Population Survey data used to establish this estimate was grossly understated. Using new methodology, the State has revised its baseline to 126,461 for FY 1997. As of the review date, the State had enrolled 61,968 children in Title XXI. The State has done an outstanding job of outreach and enrollment.

We found no major problems with the State's screen and enroll procedures. However, the application contains no disclaimer letting families know that the social security number is not required for families applying for Health Choice or that the alien status of parents of children applying for Health Choice is not required. Applicants are required to verify income at the time of application. There is no resource test. The State has 12 months continuous eligibility. Redeterminations are simplified, but not a completely passive process.

Cost sharing consists of a $50 enrollment fee per child (up to $100) payable at application, plus additional co-pays on certain allowable services. The payment of the enrollment fee is reportedly one of the major reasons for denial of applications. Several county coalitions have established foundations that provide enrollment fee scholarships for families. We found no problems with the State's cost sharing procedures.

We found the State, for the most part, has been successful in meeting its strategic objectives. Data collection for immunization and well child visits still presents a challenge.

The overall outreach effort has obviously been quite successful. We identified some areas of concern related to outreach and informational materials for the Latino community.

We found no major concerns relating to crowd out or financial reporting issues. During the review there were problems identified in the State's statistical reporting. However, these problems have subsequently been resolved.

The greatest strength of North Carolina's SCHIP program is in its coordination efforts with all the players in the area of child health. We cannot say strongly enough how impressed we were with the dedication of the representatives from the various agencies, professional organizations and advocacy groups to the constant improvement of the

program. The work of the North Carolina Health Choice for Children Task Force and the Commission on Children with Special Health Care Needs is particularly commendable.

Recommendations/observations to the State include:

- For applicants who are seasonal workers, the State may wish to consider asking the applicant how many months they have worked in the past year and using that number to extrapolate annual income, rather than having the applicant return when wages are lower.
- The State should continue to explore proven ways of promoting and measuring utilization of preventive health care services in a fee-for-service system.
- All forms required by DSS should be translated into Spanish. Information requested on the Spanish application should be the same as that requested on the English version (e.g., no request for Social Security numbers for family members who are not applying.) The State may also wish to establish an Hispanic advisory committee. (**Follow-up and State Response:** We recently confirmed that the re-enrollment correspondence is now in Spanish. The State eligibility staff has been working to get the letter/forms translated, and many have been reviewed by the Latino Work Group. The State has a new primary contact for Hispanic issues, and she is providing input on the revision of the application form. Work on the new Spanish version of the application will not begin in earnest until the new English version is finalized, but the State does intend for them to be indentical.)
- The State should make a priority of accessing comparable Medicaid data for the comparison of utilization patterns.
- The State should add a disclaimer regarding providing a Social Security number and immigration status of parents for Health Choice applicants.
- The State may wish to add information about the Hotline and health departments to denial letters.
- The State may wish to establish more collaboration between the program integrity units of DMA and BC/BS.

We commend the State for its success in the following areas:

- Utilization data and analysis available from BC/BS.
- Effective use of grant resources.
- Combining the marketing efforts of Health Check (EPSDT) and Health Choice.
- Highly effective grassroots outreach coalition strategy.
- The Health Choice Benefits Handbook contains comprehensive information in a very readable format.

# NORTH CAROLINA SCHIP REVIEW REPORT

## GENERAL PROGRAM BACKGROUND

Health Choice is a stand-alone SCHIP program. It is administered by the Division of Medical Assistance (DMA)(the Medicaid agency), which is responsible for eligibility policy, quality oversight, and funds management linkages to the federal government. County offices of the Division of Social Services establish eligibility for both Health Choice and Medicaid. Benefits are managed through the North Carolina Teachers and State Employees Comprehensive Major Medical Plan, a Blue Cross and Blue Shield (BC/BS) indemnity plan, and are paid fee-for-service. A managed care organization operating within the BC/BS plan could choose to participate in Health Choice if it agrees to limit the coinsurance amounts to those allowed under Health Choice. The Division of Public Health's Title V program is responsible for outreach and special needs services.

Health Choice became effective October 1, 1998. North Carolina covers children under 19 up to 200% of the federal poverty level (FPL). The application is a two-page, mail-in form that may be used to apply for either Health Choice or Medicaid.

The State's outreach strategy is the use of county or multi-county outreach coalitions for a grassroots approach. The local coalitions are supported by a statewide campaign which, in turn, is supported by Robert Wood Johnson grants and the Duke Endowment.

Following the review, a budgetary crisis arose within the State which resulted in the closing of SCHIP enrollment effective January 1, 2001. North Carolina statutes prohibit spending more than what was originally appropriated in the state budget, even if the additional federal money is available. An extreme overall state budget shortfall prevented any additional allocation for SCHIP. Therefore, on November 21, 2000, the State submitted an SCHIP state plan amendment to close SCHIP enrollment effective January 1, 2001, at which time enrollment was approximately 72,000. This plan amendment was approved by HCFA on February 16, 2001. Enrollment will remain frozen until the average enrollment for State Fiscal Year 2001 is 68,970. As of May 7, 2001, there were 15,348 children on the waiting list from 10,684 families. There is no planned date when the State will open enrollment. We do not make recommendations or further address this issue in this report. (**Followup:** On September 15, 2001, the Governor signed into law the new budget passed by the General Assembly that provided additional funds for the SCHIP program. This allowed the State to eliminate the waiting list effective October 8, 2001, and to cover up to 83,000 children.)

## DESCRIPTION OF STATE REVIEW

The monitoring review of North Carolina's SCHIP program, know as North Carolina Health Choice for Children (Health Choice), was conducted by the Region IV SCHIP team during the week of April 24 – 28, 2000. The review team included Michael McDaniel (HCFA, SCHIP

coordinator and team leader), Tandra Hodges (HCFA, outreach), Rosario Gilbert (HCFA, Hispanic outreach), Joyce Collins (HCFA, financial and reporting issues), John Kehoe (HRSA) and Lorine Johnson (HRSA). The purpose of the review was to establish an ongoing communication with the State regarding the implementation status of its program, identify barriers that the State may be encountering, and to offer technical assistance when requested. The review team followed the core review protocol. A copy of the review agenda is attached. (Attachment I). Recommendations are listed at the end of the Executive Summary.

## GOAL 1: REDUCING THE NUMBER OF LOW-INCOME UNINSURED CHILDREN

### A. Enrollment of eligible children into SCHIP

X Is the State having difficulty establishing a baseline estimate and/or identifying the number of children enrolled in both SCHIP and Medicaid? Is there a need for technical assistance?

*NC has modified its baseline estimate of uninsured children under 200 percent of the Federal Poverty Level (FPL) to 126,461 for FY 1997. The methodology for the baseline estimate was modified because CPS data, which had been used in making the original estimate, was considered to grossly undercount the children enrolled in the State=s Medicaid program, does not question people being sampled if they had insurance through Health Choice, and had too small a sample to be reliable. The State=s new methodology, which was developed by the University of North Carolina, starts with 1997 data from the Office of State Planning in each age category aggregated to three income categories (less than or equal to 200%; 201-300%; >300%), subtracts the actual number of Medicaid eligibles for the month of September 1997, and then subtracts the estimated number of children covered by other, non-Medicaid sources of insurance to arrive at the number of uninsured children. These original estimates were redone using this methodology, so the State=s baseline estimate would be consistent with any subsequent comparisons.*

*Estimates of the 1999 number of uninsured children was made using this methodology with 1999 data, but the actual Health Choice enrollment numbers were subtracted and considered part of the insured population. The estimated number of uninsured children in the State for FY 99 is 119, 081.*

X Please describe the State's progress at enrolling children in SCHIP and in regular Medicaid.

*The number of children with Medicaid coverage has remained fairly constant. Recently the State has introduced a couple of initiatives to increase Medicaid enrollment. The first*

*was providing 12-months continuous eligibility and the second was to provide 24-months of transitional eligibility for families that lost TANF due to work earnings. Five hundred million dollars has been dedicated to designing initiatives to get eligible people enrolled in the Medicaid program. Additionally, the State has worked extremely hard to make application and enrollment into either Medicaid or Health Choice seamless in that there is a single portal of entry and single application form for both programs.*

X Has the State met its enrollment goal? If not, what strategies is it employing to help meet that goal? Is the State having problems with particular segments of the target population? What is it doing to alleviate those problems?

*The State has surpassed its goal for enrolling children into Health Choice overall, and specifically in the income eligibility category up to 150 percent FPL. As of our visit, the State had enrolled 61,968 children, a four percent increase over the previous month. Of those, 68 percent had incomes at or below 150 percent FPL and 32 percent were between 150 to 200 percent FPL. The State is considering legislation that will expand its title XXI income eligibility to 300 percent FPL. Should this be passed and implemented, the State projects it will be able to provide insurance coverage for 80 percent of all uninsured children in the State.* ***Update Note:*** *This legislation did not pass during this legislative session. The State is having severe budgetary problems. In fact, because of underestimates in the baseline of uninsured children, the State's success in enrolling children and these budgetary problems, the State was forced to close enrollment effective January 1, 2001. The State has submitted and HCFA has approved a state plan amendment reflecting the policy and procedures for closing enrollment.* ***Second Update Note:*** *On September 15, 2001, the Governor signed into law the new budget passed by the General Assembly that provided additional funds for the SCHIP program. This allowed the State to eliminate the waiting list effective October 8, 2001, and to cover up to 83,000 children.*

X Additional question - Does the State have an effective mechanism for tracking the number of applications that have been submitted? If so, how many applications have been submitted?

*All applications are entered into the Eligibility Information System and their disposition can be tracked. However, the State did not provide us with the number of applications that have been entered.*

**B. Disenrollment and denials**

X How many denials have there been for SCHIP? Has the State program seen a significant number of denials that appear to be inappropriate? If so, how has the State handled these cases?

*According to the State, the requirement for the self-employed to submit a year=s worth of business records has resulted in many of these people failing to complete the application forms, although the State does not know exactly how many people fit into this category. Of the people who do apply for Health Choice, approximately 8 percent are denials. The predominant reasons according to data from the State's Eligibility Information System (EIS) are the enrollment fee, which is applied to families whose income exceeds 150 to 200 percent FPL and the applicant's income level is too high. Of note is the difficulty for migrant and seasonal workers whose income is extrapolated from one month's wage statement to project 12-months of income, resulting in an estimated yearly income that is above the program income limit. Applicants are told to return in a month when their wages are lower and they might qualify. Appeal rights for Health Choice eligibility are the same as for Medicaid.*

*The State maintains monthly data on terminations and causes. There were 10,760 terminations from November 1999 through March 2000. Of those, 9,149 were due to failure to complete a redetermination. The State has implemented various strategies to combat this high rate of failure to complete redeterminations. Some counties are even deputizing volunteers and/or other community agency staff to do personal follow-up with families do to re-enrollment. The State has also conducted focus groups through Covering Kids to determine the reasons families do not follow through with redeterminations. Other top reasons for termination included income exceeding the income limit, children were found to be Medicaid eligible and failure to pay the enrollment fee.*

***Recommendation:** The State may wish to consider adding a question asking the applicant how many months they worked in the past year and using that figure to multiply the pay stub amount for seasonal workers.*

**C. Specific strategic objectives relating to increasing extent of creditable health coverage among targeted low-income and other low-income children**

X How is the State progressing in meeting its strategic objectives and performance goals related to reducing the number of uninsured? Has the State developed and implemented processes to gather data and meet these goals? If not, what barriers has the State encountered and how does it intend to overcome them?

*<u>Strategic Objective #1</u>: To reduce the number of uninsured children living in families with incomes below 200% of the federal poverty guidelines. <u>Performance Goal</u>: The number of uninsured children in families with incomes below 200% of the federal poverty guidelines will be reduced by 35,000 in the first year of operation. <u>Results</u>: By the end of the first year of operation the State had enrolled 56,850 children in Health Choice. Almost all of these children would have remained uninsured were it not for the Health Choice program.*

*Strategic Objective #2: To simplify the eligibility intake process for both Title XXI and Title XIX children's programs. Performance Goal: At least 50% of Title XXI applications will occur through mail in or at non-traditional sites in the first year. Results: According to the State's evaluation report submitted to HCFA on 3/31/00, about 35% of applications are coming from non-traditional sites (mail-in and from the health departments.) While the State is not sure why the percentage is below expectations, one explanation could be that since most of the applicants fall below the 150% of poverty income level, they have an established relationship with the county DSS office and continue to go there for services.*

*Strategic Objective #3: To encourage utilization of preventive health care services. Performance Goal: The average number of visits per enrolled child will equal or exceed the Title XIX rates. Results: From the State's evaluation report, they indicate the problems encountered in measuring this goal. The State's Title XIX screening rate for FY 98 was 54%. They cannot accurately compare the Health Choice well-child visit rate to this because: 1) BC/BS uses CPT code for claims submission and there is no single, distinct code for screening as there is for Medicaid, and 2) doctors often will code the visit as a Asick≅ visit even when screening is done. Thus, Health Choice well-child visits are under-reported. Additionally, many of the children in Health Choice are older children who are less likely to be screened regularly. Another factor found during the review was that the periodicity schedule used by the Teachers= and State Employees= Benefit Plan contains less frequent recommendations for well-child visits for older children than does Health Check (EPSDT) under Medicaid.*

***State Response:*** *The State Employee's Benefit Plan, and therefore, Health Choice, has the exact same periodicity schedule for well child visits as Heath Check (Medicaid). There is an Adolescent Package of Services that has been proposed with a periodicity schedule that is now nationally recommended by AAP and others, but neither Health Check nor Health Choice follows that nationally recommended schedule of visits for adolescents.*

***Followup:*** *We are not sure where the misinformation came from, but we accept the State's statement.*

*Strategic Objective #4: To increase awareness of health care coverage options through an outreach campaign. Performance Goal: Fully implement Outreach Plan outlined in Section 5 (of the State Plan). Results: The State has systematically implemented its Outreach Plan, primarily as a county coalition approach, with very successful results.*

*Strategic Objective #5: To increase child health screenings among enrolled children. Performance Goal: At least 50% of enrolled Title XXI children will be screened in the first year, with 80% of enrolled children screened within five years. Results: See discussion in Strategic Objective #3.*

***Recommendation:*** *The State should continue to explore proven ways of promoting and measuring utilization of preventive health care services in a fee-for-service system.*

X Describe the processes, data sources, and results the State used or plans to use to measure the reduction of uninsured children in the State.

- focus studies - *Yes*
- client satisfaction surveys - *Yes*
- complaint/grievance/disenrollment reviews - *Yes*
- sentinel event reviews - *No*
- plan site visits - *No*
- HEDIS performance measurement - *No*
- other-specify - *Quality assurance survey for children with special health care needs to be conducted during fall of 2000.*

X How is the State using measures and its overall experience with program implementation to make interim corrections/improvements and to direct future program changes?

*The State continuously refines and improves the program, particularly in the area of service delivery and expansion. The State receives excellent utilization data from BC/BS. This is used to analyze where there may be a pent up need for services. Since the implementation of the program, the State has added school-based health centers as providers and expanded dental services. They plan to add a preventive mental health care program by 7/1/00 where school-based health centers can bill for up to six visits that will not be coded with a mental health diagnosis. Plans are also underway to better identify children with special health care needs and manage their care. The State also uses county enrollment data to determine which county outreach coalitions are the most successful and to share their best practices with other counties. Non-payment of the $50 enrollment fee is a significant reason for denial of applications. To eliminate this barrier several counties have organizations which provide enrollment fee scholarships. The State will be asking the legislature to eliminate the waiting period for coming off private insurance for children with special needs.* ***Followup:*** *CMS has subsequently approved a state plan amendment that eliminates the 60-day period of uninsurance before being eligible for participation in Health Choice for all children.*

X Additional question - Describe the process and results of addressing the special and behavioral health needs of the children enrolled in Medicaid expansions and SCHIP stand-alone programs?

*There is a statewide parents=advisory group for children with special health care needs. The State also works closely with the Commission on Children with Special Health Care Needs, a group of providers and advocates created by the Health Choice legislation. The Commission has a behavioral health workgroup. The State also participates at regular meetings of the North Carolina Health Choice for Children Task Force, a group*

*composed primarily of various provider representatives, including Value Options, the mental health benefits manager contracted with the Teachers and State Employees Plan. The State's goal is to make the behavioral health benefits as seamless as possible with the Medicaid program. The most recent planned change in benefits is to allow the preventive mental health visits mentioned above. There is also currently Aemergency respite care≅ available to caretakers of children with special health care needs. All of North Carolina's mental health system has been under scrutiny, and the auditor's report has been released. As a result of the auditor's report, the General Assembly will establish a Ablue ribbon≅ commission to make recommendations for changes in the system. The existing Commission on Children with Special Health Care Needs will initiate efforts to be represented on the Ablue ribbon≅ commission. It should also be noted that the BC/BS utilization data indicates there is a pent up need for outpatient drug abuse visits in the area of behavioral health.*

***We acknowledge North Carolina's excellent overall process for continuous improvement of the program, specifically the coordination with the Commission on Children with Special Health Care Needs and the North Carolina Health Choice for Children Task Force. Other states would do well to emulate this process.***

**D. Variance for family coverage**

*N/A. The State doesn't provide family coverage.*

**E. Providing premium assistance for employer-sponsored coverage under group health plans**

*N/A. The State doesn't provide employer-sponsored coverage.*

## GOAL 2: TARGETING ELIGIBLE CHILDREN THROUGH EFFECTIVE OUTREACH TECHNIQUES

**F. Strategies to target eligible children and enable enrollment and utilization of health care system**

- Has the State used the outreach strategies outlined in its State plan? If the State has deviated from its plan, why and what are the strategies being utilized?

  *North Carolina chose to use a local grassroots outreach approach with SCHIP. Each of the 100 counties formed an outreach coalition led by county social services and public health directors to pull in a diverse group of individuals representing public and private not-for-profit agencies, churches, businesses, schools/day cares, health care providers, media, consumers, etc.*

  *The efforts of local coalitions and grants are supported by a statewide outreach*

*campaign, which is coordinated by the NC Healthy Start Foundation, a private non-profit organization, under contract with the State. Campaign strategies are guided by the recommendation of a statewide outreach committee. The committee involves state, regional, and local staff working on this program directly, as well as, others who support the program though outreach. The campaign focuses on increasing awareness and enrollment into Health Check and NC Health Choice. Most activities initiated at the state level are disseminated through local networks that enhance statewide efforts.*

*See also Element A for changes.*

- What strategies have been used to educate and encourage enrollment of children eligible for SCHIP? (for example)

  *Provider Community*

  *NC Pediatric Society collaborates with DHHS to establish a provider committee (for all types of providers) to offer advice on program development and to stimulate provider support in enrolling children. (A more detailed discussion of this provider committee is included in Goal #3 related to coordination.)*

  *NC Pediatric Society and NC Academy of Family Physicians jointly publish a provider newsletter to raise awareness and participation in the program. The NC Hospital Association, the NC Dental Society, and several other provider organizations have followed suit.*

  *Hoffman-Laroche and Sepracor representatives distribute program brochures to providers as part of their normal business operations.*

  *Collaborating with local providers and medical office managers: Cabarrus Covering Kids designed an approach for working one-on-one with medical practices. Equipped with a kit of tools specifically designed for primary care providers, Covering Kids staff meet with practice personnel in their offices to discuss the insurance program, answer questions that concern providers, and explore how the practice can enroll eligible children. The kit features such tools as a pad with "prescriptions" that instruct families in how to obtain health coverage; a provider-specific FAQ (frequently asked questions) guide and a list of key contacts. Also included are program brochures, income eligibility cards, applications, a member handbook and a magnet with a Health Check/NC Health Choice number. The kit will also be used by school nurses, health departments and hospitals. Comparable approaches and material are under development for dentist, optometrists, and pharmacies.*

*Faith Community*

*Cabarrus County Covering Kids took the lead in designing and testing a strategy to engage the faith community between Mothers' Day and Fathers' Day 2000. The initiative will begin with a prayer breakfast and conclude with a celebration and awards supper. Covering Kids Captains from a broad representation of congregations will be selected and trained to effectively reach members of their congregations and help enroll children in Health Check/NC Health Choice.*

*Shortened and/or Combined Application*

*North Carolina has a joint two-page application. In addition, Buncombe County developed a computerized system that generates letters to applicants and enrollees in English and Spanish, and keeps track of enrollment fees. Applications that are mailed in or require an enrollment fee are logged into the database. Caseworkers can directly access the system for information on applicants and to enter enrollment fee information.*

*Use of the Media*

*In May-June of 1999, a paid media campaign was initiated, including statewide radio coverage, and television coverage in the State's three largest markets (Triangle, Triad, and Charlotte). All media contacts have continued to provide free airtime in the ensuing months. The federal government has assisted in this effort by providing English and Spanish video spots to all TV stations.*

*Businesses*

*Glaxo Wellcome has agreed to be a corporate sponsor to stimulate the involvement of the business community. In conjunction with the NC Healthy Start Foundation, Glaxo had begun to convene meetings of business representatives.*

*The Caroliance network of insurance agents has begun to "market" Health Choice when they approach small business as part of their normal operations.*

*Three pilot counties are involved in initiatives designed to encourage greater enrollment in Health Check/NC Health Choice through the business community. Buncombe County's project began in the fall of 1999 with a kick-off breakfast for approximately 200 human resource and district managers, small employers and benefit administrators. The video, "Kids Will Be Kids," produced by the pilot was shown. A well-respected pediatrician and other key leaders made presentations. Coalition members met with small groups of participants and distributed information packets about the program, including a brochure aimed at employers with quick and easy-to-follow suggestions for becoming involved. Since that breakfast, outreach*

*staff have been contacting the employers who attended and those who were unable to attend but were interested in learning about Health Check/NC Health Choice.*

*Guilford County Covering Kids staff have been distributing kits to employers in their area. Their colleagues in Edgecombe County have developed a detailed outreach/enrollment plan, have reviewed and refined existing business oriented materials and have created a FAQ (frequently asked questions) guide along with other pieces to formalize a Health Check/NC Health Choice tool kit for employers.*

***State Response:*** *The State would also note that they have worked with the North Carolina Hotel/Motel Association, the North Carolina Restaurant Association and the North Carolina Tax Preparers (with information in the North Carolina tax booklets).*

*Minorities: The Division of Public Health has established a minority outreach coordinator position. The Duke Endowment has provided DHHS with a two-year grant to support six minority outreach projects. Project sites are in Charlotte, Durham, Greensboro, Lumberton, Wilmington, and the Qualla Boundary, but each project will be active in several counties.*

*Special Projects: The Robert Wood Johnson Foundation has awarded North Carolina a three-year grant to develop "best practice" outreach efforts. The project is in five counties, but the results of efforts in these counties can form the basis for statewide outreach recommendations.*

- Where does your SCHIP program conduct client education and outreach activities?

  *The following provides various client education techniques/programs, as well as, educational outreach activities:*

  *Battered women shelters, community sponsored events, beneficiary's home, day care centers, faith communities, fast food restaurants, grocery stores, homeless shelters, job training centers, laundromats, libraries, local/community health centers, point of service/provider locations, public meetings/health fairs, public housing, schools/adult education sites, social services agencies, workplace, Division of Motor Vehicles Offices, not-for-profit community agencies such as YMCA/YWCA, United Way, etc.*

  *African American Adolescents: A project initiated by the Guilford County Pilot is targeting African-American families by introducing Health Check/NC Health Choice through teenagers. Using a services-learning approach ("Cascade Model"), African American college students from A&T, an historically black college in Greensboro, are helping African American high school students develop presentations on medical problems such as diabetes and sickle cell anemia, and on the children's health insurance programs. Those high school students, in turn, will share information and*

*distribute insurance applications at public housing resident meetings, churches, and other community gatherings. The Boy Scouts will also be involved in the outreach initiative, distributing information door-to-door. Guilford County Department of Social Services staff is training high school students and Boy Scouts to understand and explain the Health Check/NC Health Choice programs. Designed by two professors at North Carolina Central University in Durham, another historically black college, the Cascade Model has proven an effective tool for disseminating student-gathered health information to African American communities.*

*Articles about the program were published in the Medicaid Bulletin and in the NC Medical Society Bulletin. The NC Pediatric Society collaborated with the NC Academy of Family Physicians to publish a special edition newsletter about the program. This was distributed to all pediatricians and primary care providers in the state.*

*State Employees Health Plan and Blue Cross/Blue Shield of NC held a series of provider training workshops that targeted both public and private providers. A question and answer guide was mailed to providers following the workshops. Blue Cross/Blue Shield maintains a panel of provider representatives who provide advice and counsel to providers through a toll free number. They frequently travel to counties to work with providers or regional associations.*

*In 1999, Buncombe County produced its "Kids Will Be Kids," videotape emphasizing the importance of coverage for active, health children and teenagers. The pilot established a local "call center" that allows families to obtain information and order applications by telephone 24-hours a day. Buncombe developed a customer service manual to train Department of Social Services staff; designed posters and brochures; created inviting letters to applicants, new enrollees and those who are due to re-enroll. The pilot also put in place a system for families to receive automated telephone messages reminding them to re-enroll their children.*

- Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population.

  *The NC Family Health Resource Line (NCFHRL), which is the State's Title V/MCH Hotline, was utilized for information, referral and advocacy in relation to NC SCHIP program. Reports for the resource line provide data on total call volume, age, and race/ethnicity or callers, and how individuals learned about the line. These monthly reports are distributed to representatives of the agencies that fund the services and who use the NCFHRL as a part of the outreach efforts. The data collection system is quite flexible and can be amended to ask about new outreach initiatives (such as a radio campaign) and can be used to look closely at county level data.*

  *Members of DMA, the Division of Public Health, the North Carolina Healthy Start*

*Foundation and others meet every other month to receive updates on the NCFHRL activity/information and to coordinate outreach and educational/promotional campaigns. Call volume, level of response to outreach initiatives, and information requested are some of the agenda items discussed at these meetings. The information is used to assess the effectiveness of outreach activities and identify "next steps".*

*The State also documents initiatives such as targeted mailings of the promotional materials and newsletter articles sent to organizations/health care settings/professional associations, etc. Using a comprehensive database, the State enters all organizations that order bulk quantities of the materials (and what they order). They are able to analyze this information by geographic area, type of organization, individual materials ordered, etc., to assess the response to their efforts.*

*Staff at the Division of Public Health and the Healthy Start Foundation are in frequent contact with the local county coalitions to hear what is needed, what they are doing, and what is working. Several surveys of the local coalitions' activities have been undertaken to assess what additional resources/assistance they need from the state level to successfully meet their outreach goals.*

*The Cecil G. Sheps Center for Health Services Research/UNC-CH did a consumer survey of 1,796 newly enrolled children during 6/99-7/00. With 1,346 returned surveys, they achieved a 74% response rate. The results are just now becoming available. The response to the question, "How did you learn about NC Health Choice?" is helpful to NC outreach evaluation.* ***Update note:*** *As of 6/5/01, the Sheps Center report had not been released, but it is due soon. The findings will be included in a report to the General Assembly and may cause the State to make modifications in the program if any major problems are found.* ***Second Update note:*** *The Sheps Center report was issued September 25, 2001, and was included in the State's annual report.*

- Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness?

  *In general, NC has done well with SCHIP outreach because the major thrust was a local grassroots outreach coalition strategy. Each of the 100 counties was asked to form a local outreach coalition with diverse representation. That strategy assured that our outreach would be more personal and tailored to the local community. The state's role then became one of supporting the local coalitions' efforts by providing the tools (print materials, electronic media, programmatic and data updates, consultation/technical assistance, workshops, etc.).*

  *NC has been particularly successful in outreach to families at the lower income*

*levels. Of the children enrolled, approximately 70% are in families below 150% FPL; 30% are above.*

*With regards to targeting outreach to minority populations, NC has based its strategy on research that shows that outreach is most successfully accomplished when it is personal, from someone they trust, preferably of their own race, from their media, from their own community, church, or business. See Element G for issues /barriers related to Hispanic outreach.*

- In simplifying enrollment applications, has the State pre-tested the application in different populations, i.e. is the application process working and in which populations are they able to actually enroll kids successfully?

  *Buncombe County had a pilot that began with the application. After reviewing the applications used in other parts of the county, seeking input from NC Department of Medical Assistance staff, graphics designers and others, the pilot designed a more user-friendly application. The application is being field-tested and will be refined in the first part of the coming year. See Element G for issues related to the Spanish language applications.*

- Has the State provided training to individuals conducting outreach?

  *See above responses.*

**G. Effectiveness of chosen outreach and enrollment strategies**

- Is the State conducting any studies/evaluations of their enrollment and outreach strategies? What study methodologies are they using? What do preliminary findings show?

  *Preliminary findings show the total number of Medicaid eligible children increased between 1997 and 1999 from 491,070 (1997) to 497,239 (1999), although the percentage of low-income children (<200% FPL) remained relatively constant (61%).*

  *The numbers of Medicaid children in the Medically Indigent Children (MIC)(poverty level) program went up from 231,891 in October 1998 to 281,373 in October 1999, an increase of 49,482 children. During the same time period, the children on TANF went down from 110,976 in October 1998 to 86,759 in October 1999, for a loss of 24,117.*

- Have any outreach strategies been more successful in reaching specific groups? In reaching the general target population? Have there been any identified barriers to

enrollment, e.g. public charge, application process issues, access (i.e. physical barriers including transportation issues, language and literacy barriers)?

*Hispanic Enrollment: According to Rogelio Valencia, Hispanic Ombudsman, there are many Latino children in NC communities that are eligible but not enrolled in Health Choice. Due to infrastructure and budgetary restraints, data on actual numbers is not available.*

*There is no funding to have an adequate number of bilingual staff in some counties to assist Spanish-speaking population.*

*The Outreach Advisory Committee has requested additional funds from the Duke Endowment to conduct outreach activities in counties with a high density of Hispanic population.*

*Hispanic Outreach & Services: The Duke Endowment is redesigning printed materials and will conduct a campaign to make the Hispanic community aware of the availability of these health insurance programs. They will use Mountain Health Coordinators, non-profit organizations, churches, etc., to carry the message to this population. The Duke Endowment has notified Latino community outreach coalitions that outreach grants are ending at the end of this summer.*

*Latino Campaign: The State wants to create a Latino Board to field test new materials for Latino outreach, find out what tools work best and create materials that appeal to this community.* ***Follow-up:*** *The Latino Work Group convened as a subcommittee of the State Health Check/NC Health Choice Outreach Coalition. They advocate for the needs of the Latino population and work to remove barriers. Recent efforts have included:*

1. *Recommended revisions to the state application as well as translations of other forms/letters used by the State and county agencies.*
2. *Identification of Spanish speaking contacts at county level to whom families may be referred from the bilingual NC Family Health Resources Line.*
3. *Development of a directory of clinics that are able to serve the uninsured population (e.g., Latino families who may not qualify for Medicaid or Health Choice due to the five-year waiting period or other barriers.)*
4. *Development of a network of individuals within the Latino communities across the State who can share programmatic information and updates.*

*The Hispanic version of the application is different from the English version. The Hispanic application includes questions about race; the English version doesn't include that question. Latino is not a race, rather a group of people. If a reference to race is made, it should use the categories used in the latest census.*

*Another issue is the SSN: The Hispanic application requests SSNs for all the members of the family; the English version requires only the applicant's number.*

*Barriers: Public Charge is an issue; mobility; not many bilingual providers, Latinos in 12 counties go to Wilmington for services. There are about 1,000 farm workers and approximately 2,000 children, only 1 or 2 percent are enrolled in Health Choice because of lack of transportation. The Ombudsman has provided training to DSS workers in an effort to reduce the number of applications being denied, incorrect assessments, etc.*

*One glaring issue is the application is required to be completed in English and the State's approval; request for additional information correspondence is in English. DMA has translated some of the forms but had not distributed them.*

***Recommendation:*** *We recommended that all the forms required by DSS be translated to Spanish and that information requested on the Spanish application be the same as that requested on the English version (i.e., no request for SSNs for family members who are not applying.) (See recommendation in Element I.)*

***Follow-up:*** *We recently confirmed that the re-enrollment correspondence is now in Spanish.*

***State Response:*** *The State eligibility staff has been working to get the letter/forms translated, and many have been reviewed by the Latino Work Group. The State has a new primary contact for Hispanic issues, and she is providing input on the revision of the application form. Work on the new Spanish version of the application will not begin in earnest until the new English version is finalized, but the State does intend for them to be identical.*

## GOAL 3: COORDINATION WITH OTHER STATE AND FEDERAL PROGRAMS AND THE PRIVATE MARKET

### H. Program coordination

X Additional question - How is SCHIP coordinating with other State programs with respect to the following: administration, service delivery, service payment, procurement, contracting, data collection, quality assurance, other?

*The North Carolina Family Health Resource Line, which is the State's Title V/MCH Hotline provides information on Health Choice, Medicaid, Title V and community health care resources. This is an excellent resource in referring callers to appropriate services and programs in their communities. The hotline does not track people calling in individually, but does correlate program enrollment numbers with outreach information requested and used by counties.*

*Program coordination among public and private agencies is one of the greatest strengths of North Carolina's title XXI program and is emphasized in every discussion with all*

*participants and at every level of State government. The program has been developed to be seamless to applicants. The State's Department of Maternal and Child Health, located in the county health departments oversees outreach through local coalitions. The State has also partnered with the Women, Infants and Children (WIC) program and Nutrition Services to promote Health Choice. There is one application form used for Health Choice or Medicaid. Applications can be filled out at county health departments, local Department of Social Service's offices or mailed in. Eligibility is determined by the Department of Social Services for both programs and forwards the enrollment information to Blue Cross and Blue Shield who generates the identification card and sends out the benefit book within 24 hours.* ***State Response:*** *The partnering with WIC has resulted in 435,000 contacts annually (through use of WIC recertification folders that market Health Check/Health Choice). Also, DHHS/DPH Immunization Program Representatives that visit provider offices with the Universal Childhood Vaccine Distribution Program distribute provider information packets regarding Health Check/Health Choice.*

*Benefits are managed by the State Health Benefits Office through the North Carolina Teachers and State Employees Comprehensive Major Medical Plan. Claims information is handled through Blue Cross and Blue Shield. Claims for mental health case management is provided through Value Options, a subsidiary of Blue Cross and Blue Shield. These groups have frequent contact and meetings in order to coordinate their efforts and work through issues as they arise. There is also a provider workgroup, composed of members from State agencies and physicians representing each type of service provided through the program. Coverage, coordination, provider outreach and education as well as program direction questions and issues are worked through at monthly meetings of this group.* ***This is clearly an area in which North Carolina provides a wonderfully effective model to other States.***

*The State has said that the fact that Health Choice is designed as a bridge between Medicaid and the Division of Information Systems and EDS Federal and the Blue Cross and Blue Shield system made data reporting particularly challenging. Data is provided by Blue Cross and Blue Shield from paid claims data, which is collected electronically and validated for completeness. Program norms are taken from the State Teacher's Plan, so utilization data is comparable. Unfortunately, Health Choice does not currently have access to Medicaid data, although the State is working on getting this data. However, until this data is available, the State cannot complete the loop in having comparable data across programs.*

***Recommendation:*** *We recommend that the State make a priority of accessing comparable Medicaid data for comparing utilization patterns.*

**I. Screen and enroll**

X Please describe the State's method for screening SCHIP applicants for Medicaid eligibility and enrolling Medicaid eligible children into Medicaid if different than in State plan (e.g., use of joint applications for SCHIP and Medicaid).

X Are joint applications used to determine eligibility for other State programs? Are these joint efforts working well?

X How is program coordinating between/among other children's health-related programs, (e.g., Medicaid, Title V, WIC, community and migrant health centers, etc) to assure compliance with screen and enroll requirements under Title XXI?

X Is there any follow-up with families whose children have been identified as Medicaid eligible to see if they are actually enrolled in Medicaid? If so, what has been found? Are there any reports that the State can provide?

X What are beneficiaries= hearing rights if eligibility is denied?

*The same two-page application form is used for both Health Choice and Medicaid. An application may be made at the Department of Social Services (DSS), requested by phone or mail, picked up at health departments or other local entities. Applications may be returned in person or through the mail. The application is considered an application for medical coverage with eligibility being evaluated first for Medicaid and if ineligible, for Health Choice. Eligibility for either program is determined by the DSS. The intent is to make health care available to clients with a process that is as seamless between programs as possible. Applications for enrollment are available in either English or Spanish, although the Spanish version is simply a translation of the English and the application must be completed in English. Caseworkers screen the application and decide if it is complete. If more information is needed, the family is contacted. Per the North Carolina Health Choice statute, proof of income is required. DSS is allowed 45 days to process the application, although the average time taken is two weeks. The family is sent a letter if an enrollment fee is needed for Health Choice. The fee must be paid before the child is enrolled. Enrollment information for Health Choice is then forwarded to Blue Cross and Blue Shield, who sends out the membership card and brochure in 24 hours. The enrollment period is 12 months. EIS notifies the family if they are not eligible for either program. Should eligibility be denied, applicants have the same appeal rights for Health Choice as they do for Medicaid.*

*Reeligibility determination at the end of the 12 months is handled similarly to the initial application. It is a simple, but not passive, reenrollment process. A reenrollment notice is automatically sent to the family at the end of the tenth month of eligibility. If the form is not returned by the 25th of the eleventh month, another notice is sent. Counties are required to do follow-up if the form is not returned and follow-up varies by the resources available in each county. Once the form is returned, it is evaluated first for Medicaid eligibility and then for Health Choice. A form can be accepted as reenrollment up to the tenth day of the month following the end of the initial 12-month period. After that date, the family needs to file a new application. Should they be deemed still eligible for Health Choice, their eligibility period starts at the beginning of the twelfth month, so there is no interruption in available services. Data shows that approximately 16 to 20 percent of applicants filing for reenrollment in Health Choice are found eligible for Medicaid and enrolled in that program.*

*The State noted that training of workers is very important in this process and have implemented Health Choice reviews, known as Corrective Action Record Reviews (CARR) as a check on the training that is being provided. The goal of the process is for counties to follow-up on leads to potential problems. As of April 19, 2000, 1211 cases were reviewed in 48 counties. Of the 1211 cases, 726 appeared to be correct and 485 were found to have potential problems that could affect eligibility for Health Choice or Medicaid. The majority of problems had to do with failure to verify and project income correctly, failure to verify deductions from income and failure to verify possible health care coverage. Ten cases were identified in which children appear to be eligible for Medicaid rather than for Health Choice. Medicaid Program Representatives discuss these problems with the counties and provide additional training, as needed.*

*Regarding the application and associated materials, there is currently no disclaimer on the form letting families know that the social security number is not required for families applying for Health Choice or that the alien status of parents of children applying for Health Choice is not required. This should be added. Buncombe County is looking at the application form and has redesigned it to be more consumer friendly. They are currently field-testing the new form and will be submitting the results to the State for their consideration.*

***Recommendation:** The State should add a disclaimer regarding providing a social security number and alien status of parents for Health Choice applicants.*

**J. Referral of eligible children to other State programs, when appropriate**

Please describe referral processes including:

X Referral by Medicaid eligibility workers of non-Medicaid eligible children to SCHIP, and

X Referral of non-SCHIP, non-Medicaid eligible children to other publicly-funded child health programs, e.g., MCH

*The State's toll-free Hotline is a great asset in providing assistance and program referrals to families seeking medical assistance who may not be eligible for Medical Assistance or Health Choice. People are also referred to other programs through the county health departments as they are doing outreach and assisting people in filling out applications. DSS workers are also provided training and refer people to other programs if their income is too high for Medicaid or Health Choice.*

***Recommendation:** We would suggest that the State consider adding information about the Hotline and health departments to denial letters.*

**K. Coordination of outreach efforts with current Medicaid and other State-only children's health insurance programs**

- What efforts has the State made to coordinate outreach efforts with other relevant entities in the State, e.g. immunization programs, family planning, WIC, Title V, other State agencies, etc.? (for example):

  *The management structure of NC Health Choice for Children is built intrinsically on coordination among existing agencies. Benefits are managed through the NC Teachers and State Employees Comprehensive Major Medical Plan. County Medicaid offices establish eligibility. The Division of Medical Assistance is responsible for eligibility policy, quality oversight, and funds management linkages to the federal government. The Division of Public Health's Title V program is responsible for outreach and special needs services. Two separate private companies and one public agency deal with different aspects of information management. Eligibility information is handled through the Division of Information Management and EDS federal. Claims information is handled through Blue Cross/Blue Shield, claims processing agent for the State Employees health plan. Ongoing cooperative, coordinated efforts among all of these entities have been essential to the successful operation of this program. Telephone, email and at least weekly meetings have been the mechanisms used for program management.*

- Conducting data matches with other programs which may serve similar populations:

  *While a few counties are conducting matches with the local school system to identify potential eligibles, this is not being done on a statewide basis because it would require negotiation and a memorandum of agreement with each of the 117 school districts in the State.*

- Coordination with other State agencies (list agencies)

  *Guilford County Covering Kids Coalition is one of 167 national and five state pilot projects funded with a three-year grant from the Robert Wood Johnson Foundation. The goals of this project are to design and conduct outreach programs that identify and enroll eligible children into Medicaid and other health coverage programs; simplify enrollment processes; and coordinate existing coverage programs for low-income children.*

  *The NC Health Choice program is working on development of a mechanism to identify children with special needs. The purpose of this identification is three-fold: 1) to identify children who may need additional services not covered under the traditional NC Health Choice service package; 2) to monitor the services received by children with special health needs to ensure that they are receiving appropriate services; and 3) to identify children who may need service coordination and/or emergency respite care. Implementation of the mechanism will be a collaborative effort between the Division of Public Health, the North Carolina Division of Medical Assistance, the NC State Employees Health plan, and Blue Cross Blue Shield of NC.*

**L. Ability of beneficiaries and the public to obtain information on program**

X Describe the State's process for educating beneficiaries about the following (for example): benefits, accessing services (i.e., benefit carve-outs, provider networks), choice of health plans/providers, grievance and appeals procedures, cultural competency and language issues

*When DSS approves an application, the information is sent to BC/BS. Enrollment information is entered into the BC/BS system and a Health Choice card and benefit handbook mailed within 24 hours. The handbook is available in English and Spanish. Mental health and chemical dependency services and inpatient hospital admissions must be precertified. How to obtain precertification is on the back of the card. Information about accessing care (they can go to any licensed medical professional whose care or treatment is covered by the plan) and medical appeals procedures is in the handbook. Appeals procedures related to eligibility are contained in the denial notice. Information about the program in general may also be obtained by calling the hotline.*

*The State does receive calls from providers and members who are unfamiliar with the traditional indemnity program approach. Members may ask which doctors or dentists in their community participate in the program. The State will provide over the phone the names of providers who have billed Health Choice.*

X Describe the State' process for educating beneficiaries about cost-sharing requirements including (for example):
- notification of the amount of cost-sharing individual beneficiaries will be required to pay
- notification of how and where premiums and/or copays are to be paid
- notification that cost sharing is not allowed for certain services, e.g., well-baby care, preventive care, etc.
- notification of any rules related to cost-sharing which could affect access or utilization of services, e.g., nonpayment of premiums results in disenrollment for a specified time, coverage does not begin for a specified period after enrollment into the program
- inclusion of educational efforts in contracts with enrollment brokers

*The DSS worker determines if the applicant must pay an enrollment fee of $50 per child (up to $100) because the income is over 150% of the FPL. They request payment from the family, and this must be paid before the application can be approved. The application indicates that additional co-pays may be imposed, but does not contain details. Details about co-pay amounts and where to pay them are contained in the handbook. In addition, co-pay amounts are on the card.* ***The State is deservedly proud of the handbook as it contains all the information a beneficiary needs to know in a very readable format.*** *Each county may also develop its own informational material as part of its outreach strategy.*

*The system calculates each family' 5% cap on cost sharing, and a notice is mailed on the day the family reaches its cap to inform them they are no longer responsible for any co-pays. They are informed to keep the notice and take it to their providers. To date, no family has met the 5% cap.*

**M. Access and service delivery issues**

X Do beneficiaries have adequate access to covered services? (adequacy could be determined through factors such as beneficiary input from surveys, sizes of provider panels as compared to the number of enrollees, geographic distribution of providers, etc.)

*Access to covered services is not a problem except for dental services. Lack of dental providers is still a problem. North Carolina is below average with the number of dentists overall, and they have no licensure reciprocity. There is only one dental school, and public health doesn't operate dental services clinics, only preventive care.*

*As reported in the State's evaluation report submitted to HCFA 3/31/00, they have a beneficiary survey underway conducted by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill that will provide information about access to care. The study results will be available in the spring of 2001.* ***Update note:*** *As of 6/5/01, the Sheps Center report had not been released, but it is due soon.* ***Second Update note:*** *The Sheps Center report was issued September 25, 2001, and was included in the State's annual report.*

X Please describe the State's progress in increasing access to care for SCHIP and Medicaid-eligible children.

*Because access was immediately available for most services with the implementation of the program, the State has focused on increasing access in those areas where it was lacking. Special emphasis has been on dental services, behavioral health, and increasing access for children with special needs. The Health Choice for Children Task Force continuously addresses access issues.*

*The State Medicaid program has an oral health initiative to increase access to dental services. Barriers to care have been: low payment rates to providers; failure of beneficiaries to keep appointments; geographic barriers; language barriers; and attitudes of the providers. They are doing outreach to dentists before notifying beneficiaries of the initiative. Additional dental services were added to the plan 7/1/99. As of 1/1/00, a pilot project began in ten counties to allow physicians and physician's extenders to provide a preventive oral health screening package for children birth to age 3 that includes an oral health screening, nutrition counseling, and application of a fluoride varnish if there are teeth present. Up to six encounters will be allowed. EPSDT coordinators will link families to dental providers and help them keep appointments. The next proposal to will be to cover surgical extractions and space maintainers. They have received support from the North Carolina Dental Society, but individual dentists still haven't bought into the program.*

*The State is currently working on a way to identify children with special health care needs.*

*This is needed to be able to identify the children who need special services and to be able to coordinate their care. In addition to finding a way for parents to self identify their special needs children, both the Cecil G. Sheps Center at UNC-Chapel Hill and DMA, through a contract to conduct a Consumer Assessment for Health Plans Survey (CAHPS) with UNC-Charlotte will use their client satisfaction surveys to identify special needs children. Ultimately, the State is working toward a case management program for these children without Alabeling≅ them.*

X How is the State assuring adequate delivery of health care to enrolled children, particularly with respect to well-baby care, well-child care, and immunizations?

*Well-baby and well-child care, dental, vision and hearing benefits, and immunizations are all covered by the plan, and as required, there is no co-pay for preventive services. There was some concern about the periodicity schedule adopted by the Teachers= and State Employees= Plan because it does not coincide with the current recommendations of the American Academy of Pediatrics. The State pays for unlimited well-baby visits for children under one, three visits per year for children ages one and two, one visit per year for children ages three through six, and one visit every three years for children ages seven to nineteen. Additional office visits for a sick child are unlimited with a $5 co-pay. The Health Choice Handbook stresses going to the doctor for preventive care, provides the number of visits allowed, and indicates there is no co-pay. However, the BC/BS system for capturing utilization data doesn't adequately capture how successful the program has been in assuring preventive care. It can identify the number of well-child claims and immunizations, but there may be miscoding of well-child visits as office visits. From October 1998 through September 1999, there were a total of 9,616 well-child visit claims, but we do not know how many there should have been. The State is working diligently to encourage preventive care. The DHHS Division of Women's and Children's Health, which has the lead on outreach activities, is also active in promoting the use of preventive services through monthly outreach coalition letters. They also plan to issue quarterly wellness letters. Health Check (EPSDT) coordinators in the counties work with Health Choice families as well as Medicaid to remind them to take their children in for check-ups. BC/BS also has plans for greater communication with families to encourage more preventive services. During the review, we attended a meeting of the NC Health Choice for Children Task Force, a group comprised mostly of providers that was created when Health Choice was created. The Task Force focuses on assuring adequate delivery of health care by continuously making recommendations to the state legislature for improvement.*

**N. Quality and appropriateness of care**

X Has the State been able to implement and obtain data using the methods outlined in the SCHIP plan to assure the quality and appropriateness of care?

*Yes.*

X Which quality assessment and improvement strategies (e.g. quality of care standards, performance measurement, information and reporting strategies, licensing standards, credentialing, periodic and external reviews) has the State been able to use successfully, if any?

*The State has used beneficiary satisfaction surveys, complaints and grievances monitoring, and utilization data from paid claims to measure quality and develop improvement strategies. Through a contract with the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill, the State has surveyed beneficiaries after the program had been operational for ten months, and plans are to resurvey the original group as well as a group of new enrollees. The results of the original survey were not available at the time of the review. In addition to the Sheps Center surveys, the DMA Managed Care unit has added Health Choice to its contract (with UNC-Charlotte) to assess patient satisfaction with Medicaid Managed Care using the NCQA Consumer Assessment of Heath Plan Survey (CAPHS). The survey will look at patient satisfaction and access to primary and specialty care among Health Choice enrollees and compare this to Medicaid. Utilization data on well-child visits, immunizations, ambulatory visits, emergency room visits, hospital stays, and for focus studies such as asthma, comes from BC/BS.*

X Is the State experiencing difficulty in measuring the performance goals outlined in the State's plan? Can the Department assist in reducing barriers to collecting this data?

*Although the State experienced some delays in programming to access data because of Y2K and HIPAA activities, they have been successful in measuring their performance goals in all areas except the rate of well-child screenings. They have not been able to accurately measure preventive screenings because Health Choice uses the Blue Cross CPT coding system which has no single distinct code for screening, and as mentioned earlier, it is likely that providers are conducting well-child screens in connection with a Asick≅ visit and coding it as a Asick≅ visit. Also, with their rapidly expanding enrollment during this first year of the program, it has been difficult to capture exactly how many of the newly enrolled children should receive a screening.*

**O. Delivery Systems**

X Has the State established and defined a delivery system for the SCHIP program? (comprehensive risk managed care organizations (MCOs) - statewide, mandatory enrollment, # of MCOs; primary care case management (PCCM); non-comprehensive risk contractors for selected services (e.g., MH, dental, vision) - specify if services are carved out; indemnity/FFS - specify if services are carved out; other)

*Health Choice is a traditional indemnity program with any willing provider participation. Mental health and substance abuse services are case managed separately by a company called Value Options, but they are not a carve out.*

X Has the State faced any barriers related to acquiring and maintaining appropriate delivery systems for SCHIP enrollees across the State (or service area)?

*No. It was an established system.*

X How is the State program addressing issues related to varying geography, including varying populations and needs by region, such as rural and urban settings and children with special health care needs?

*As stated earlier, provider participation and access to care are not major problems except in the area of dental services. The providers' advisory panel to the program constantly assesses needed changes in the benefits structure for the general population, and the Special Needs Commission assesses needed changes for the special needs population. The State has been particularly attuned to children with special needs. These children are currently being identified based on an analysis of ICD-9 codes contained in the Health Choice claims system. However, the Commission is trying to develop a more comprehensive system based on both self-identification by family members and an analysis of functional status. Most services for children with special needs are covered under the core services of the plan. However, there is a process for obtaining additional wrap-around services not otherwise covered under the plan through a review by the Medical Director of the Children and Youth Branch of the Women's and Children's Health Section. The inclusion of these services makes the benefit package equivalent to the Medicaid covered services.*

X How is the State program working to coordinate with and among other health-related and children's service systems?

*Implementation of the identification of special needs children and the coordination of their care will be a collaborative effort among the Division of Public Health, DMA, the State Employees Health Plan, and BC/BS.*

X What mechanisms does the State use to monitor and assess provider capacity and participation in SCHIP?

*BC/BS keeps lists of all providers (primary care and dental) who submit claims to participate in the program by county. Provider accessibility is monitored through beneficiary satisfaction surveys and complaint logs.*

**P. Provision of Assistance to Indians**

X Did the State consult with Federally-recognized Tribes and other Indian Tribes and organizations in development and implementation of SCHIP?

X Does the State continue to follow the procedures outlined in their SCHIP plan regarding provision of services to targeted low-income American Indian/Alaskan Native children?

X Do Native American/Alaskan Natives report that they are able to access SCHIP services? If

not, does the State have any data on what barriers are reported? What is the State doing to respond to the reported barriers?

X What methods does the State plan to utilize to ensure ongoing input from these groups?

*The State SCHIP Coordinator is also the Native American Coordinator. The Eastern Band of Cherokee and Catawba were involved in early development of the State's SCHIP plan, and because of the direct connection to the SCHIP Coordinator, continue to have an easy avenue for input. A representative from the Commission on Indian Affairs serves on the state Outreach Committee. As stated previously, the Catawba were particularly pleased with the way the State handled outreach activity to the Tribe. The State received an endowment grant from the Duke Foundation for funding of six outreach projects, two of which are targeted to Native Americans. A Cherokee has been hired to help with completing applications on the reservation. The State is in the process of submitting its state plan amendment to eliminate any cost-sharing requirements for the federally recognized tribes. There have been no reported problems from the tribes regarding access to SCHIP services.*

## GOAL 5: ASSURING THAT STATES MEET STATUTORY FEDERAL AND STATE REQUIREMENTS

### Q. Crowd out Strategies

X How is the State monitoring crowd out (if different than effort outlined in the State plan)?

*For the first six months of the program, a family could not enroll if they had dropped health insurance (without one of the excepted reasons) within that time. After the first six months, the waiting period became two months.*

*As other states, North Carolina reports that it is difficult to monitor crowd out because it primarily depends on self-reported information. The State also notes that 38.5% of all Health Choice enrollees come directly from Medicaid coverage where crowd out would not likely be an issue. The State has analyzed data from the survey by the Cecil G. Sheps Center to obtain very rough estimates of the number of families who have dropped health insurance in order to become eligible for Health Choice. Based on responses to three questions on the survey, the State estimates an upper limit crowd out rate for all enrollees is 8.3%. If the State learns of unreported health insurance or the dropping of health insurance, violators are turned over to the fraud and abuse section of DMA.*

X To what extent is the State finding the existence of crowd out as a result of the implementation of SCHIP? Please indicate if this is anecdotal information.

*There is no indication that crowd out is a significant problem.*

X Has the State conducted any studies/evaluations of crowd out? What study methodologies are being used?

*Only as indicated above.*

X Additional questions - Have there been any issues raised regarding the use of anti-crowd out mechanisms (e.g., limiting access to coverage for eligible children)? If so, please describe. Are there differences in the existence/level of crowd out across programs?

*The State would like to eliminate the waiting period for children with special health care needs. Generally, the reason families with special needs children want to enroll in Health Choice is because the insurance they have is totally inadequate or is about to expire. There was discussion during the review of submission of a state plan to eliminate the waiting period.* ***Follow-up:*** *The State has subsequently submitted an amendment and it was approved by HCFA on October 19, 2000.*

**R. Cost-sharing for enrollees**

X Please describe any cost sharing the State is imposing on beneficiaries, including any requirements or exceptions for Native Americans if different from approved State plan. Types of cost-sharing used:9 premiums; 9 enrollment fees; 9 deductibles; 9 coinsurance/copayments; 9 others.

*For families with income above 150% of the FPL, there is a $50 enrollment fee for one child and $100 fee for two or more children once a year at the time of enrollment. Copayments are: $5 for a non-preventive physician's visit*; *$6 for prescription drugs, and $20 for non-emergency use of the emergency room. Subsequent to this review, the State has submitted its state plan amendment to eliminate cost sharing for members of Federally-recognized Tribes.* ***Follow-up:*** *This plan amendment was approved October 19, 2000.*

X Does this system ensure that cost-sharing requirements do not favor children from families of higher income?

*Yes*

X Describe the process the SCHIP program is using to monitor that the aggregate cost-sharing does not exceed 5% of family income, including the methods through which the families will be notified if different from the approved State plan. 9 shoebox method 9 health plan administrator 9 audit reconciliation 9 other

*At the time of approval a letter is mailed to the family notifying them of their cost-sharing requirements and their cap is set based on verified income. The BC/BS claims payment system keeps track of the total cost sharing of each family. When the family has reached its 5% cap, a letter is generated from BC/BS informing them of this fact and asking them to present the letter to their providers so they will not have to pay any more copayments.*

X Describe the process by which the State will assure that beneficiaries are not directly billed for premiums or other coinsurance and subsequently reimbursed if they have reached the 5% cap on cost-sharing.

*See above.*

X How many beneficiaries have reached the 5% cap on cost sharing? (if State has data available)

*None.*

X Is there any evidence of cost sharing creating a barrier to access and utilization of services?

*The State has found that the leading cause of denial of applications (for all income levels) is failure to pay the enrollment fee - 30% of denied applications. There were slightly over 4,000 children who were denied during the first year of the program for failure to pay enrollment fees. However, some counties have developed scholarships through foundations or other organizations which pay families=enrollment fees. In Guilford County all enrollment fees are paid by a scholarship fund supported by the Moses Cone/Wesley Long Community Health Foundation. After the child is enrolled, the family is sent a letter informing them that: 1) They may make a gift to the fund to cover the amount required to enroll their children, and 2) They are still responsible for copayments.*

X Additional question - Has the State done an assessment of the effects of premiums on participation or effects of cost sharing on utilization?

*See above.*

**S. Objective and independent measurement of health plan compliance**

*This delivery system is an indemnity plan. The State has no contracts with managed care plans under Health Choice. Independent measurement and assessment of the program, as stated previously, is through a contract with the UNC - Charlotte to perform the NCQA Consumer Assessment of Health Plan Survey (CAPHS) and analyze the results with comparisons across all Medicaid managed care programs and Health Choice. DMA also plans to produce utilization data that corresponds to Medicaid managed care utilization data. Also, as stated previously, the State has a contract with the Cecil G. Sheps Center for Health Services Research at the UNC - Chapel Hill to conduct a beneficiary survey in two waves to provide information on access to care in the Health Choice program. The complete study results will not be available until the spring of 2001.*

**T. Assurance State will provide reports to Secretary as required**

X Has the State identified any problems in meeting reporting requirements under title XXI?

For quarterly financial and statistical and annual reports and State evaluations? If so, what are you doing to address data problems? Does the State require technical assistance to meet reporting requirements?

*The Regional Office (RO) has worked closely with the State on quarterly expenditure reporting (HCFA-21) and has provided technical assistance, when needed. There have been no deficiencies noted by the RO regarding the State's expenditure reporting of SCHIP.*

*The State has been deficient in its statistical reporting. As of May 2000, the State had not entered its SCHIP statistical information into the Statistical Information Management System (SIMS) for the 1st and 2nd quarters of FY 2000. According to State personnel, the primary reasons for the delinquency are as follows. First, the State did not receive SIMS instructions from HCFA timely; therefore, the State has to simulate what would have been known relative to transactions had there been a timely receipt of instructions, which is very time consuming. Second, there is insufficient coordination of data input among State personnel (i.e., the same person who enters the HCFA-64 and HCFA-21 into MBES/CBES is responsible for inputting the statistical information into SIMS, thus delays are caused due to time constraints). State personnel responsible for collecting and inputting the statistical data have agreed to better coordinate the timing of the receipt and input of the statistical information.*

*The State has not been able to print its statistical reports from MBES/CBES to proof its data input. As a result, the RO has provided assistance to the State by printing the State's statistical reports from MBES/CBES and faxing them to the State so it can proof its data input. This printing problem should be resolved once statistical reporting becomes web-based.*

***Follow-up:** The statistical reporting problems have been resolved.*

**U. Budget submission**

X Are there issues related to the State's budget submission? Have there been any unexpected changes in the budget and expenditures for the program? Issues may be related to the following: planned use of funds; sources of non-Federal share of plan expenditures; assurance of maintaining specified expenditures (e.g., administration, outreach, services) to the 10% cap deferrals; disallowances; review for potential fraud and abuse; change in the use of a Stateɔs allocation.

*SCHIP federal allotments for FFY 98 and FFY 99 totaled $79,508,462 and $79,132,966, respectively. Federal share of expenditures for FFY 98 and FFY 99 totaled $0 and $34,921,019, respectively. Due to the administrative claiming limit of 10% of expenditures for services, the State has had to defer incurred administrative expenses exceeding the 10% limitation for FFY 98, FFY 99, and through March 31, 2000 to later quarters in order to stay within the 10% limit. As of the quarter ended June 30, 2000, the state has claimed all*

*administrative expenses incurred, as reported on the HCFA-21 for the 3rd quarter of FFY 2000.*

*The Regional Office (RO) has worked closely with the State on quarterly budgetary reporting (HCFA-21B) and has provided technical assistance, when needed. There have been no deficiencies noted by the RO regarding the State's budgetary reporting of SCHIP.*

**V. Program Integrity**

X Does the program provide safeguards necessary to ensure that eligibility is appropriately determined?

*Yes. See response to Element I.*

X How has the State ensured that contracts with MCOs include enrollment and other required data and the MCO has attested to the accuracy and integrity of enrollee claims and payment data? *N/A*

X With fee-for-service systems, has the State established procedures to ensure the integrity of provider claims?

*Yes, BC/BS has a provider fraud unit that monitors claims. They look at claims data in a potentially troublesome area. For example, they may pull data from a chiropractor who serves a large percentage of children. They look at bundling, upcoding, miscoding, and experimental procedures. They investigate reported incidents where non-certified staff may be performing procedures. Tips come from the Explanation of Benefits (EOB) and the fraud hotline. There has been only one incident of fraud so far in Health Choice.*

X Has the State ensured that MCOs have procedures in place to guard against and investigate fraud and abuse? Is the State enforcing MCO compliance with all Federal and State standards and does it have a mechanism for reporting fraud and abuse to the proper governmental authorities? *N/A*

X Does the program include procedures to ensure program integrity and detection of fraud and abuse? Does the State have procedures for coordination between the State program integrity unit and the OIG, DOJ, FBI, etc?

*See above. The State program integrity unit does have procedures for coordination with the OIG, DOJ and FBI.*

X How has the State facilitated communication between it and the public in terms of reporting possible fraud or abuse? (Does it have a toll-free number for this purpose?)

*Yes, there is a fraud hotline both at BC/BS and DMA.*

X For those States with separate SCHIP programs, is the State applying the Medicaid privacy protections pertaining to the protection of enrollee data, medical records and mental health history, and privacy of minors? *Yes*